Caritas Good Samaritan Medical Center *and* SEIU, Local 767, Hospital Workers Union, AFL–CIO. Case 1–CA–39471

September 8, 2003

DECISION AND ORDER

BY CHAIRMAN BATTISTA AND MEMBERS LIEBMAN AND SCHAUMBER

On September 12, 2002, Administrative Law Judge Earl E. Shamwell Jr. issued the attached decision. The Respondent filed exceptions and a supporting brief, and the General Counsel filed cross-exceptions and a supporting brief.[1]

The National Labor Relations Board has delegated its authority in this proceeding to a three-member panel.

The Board has considered the decision and the record in light of the exceptions and briefs and has decided to affirm the judge's rulings, findings, and conclusions only to the extent consistent with this Decision and Order.

The complaint alleges that the Respondent violated Section 8(a)(5) and (1) of the Act by unilaterally changing the bargaining unit employees' health insurance, without first bargaining with the Union.[2] In its defense, the Respondent asserts, inter alia, that the case should be deferred to the grievance-arbitration procedure contained in the parties' collective-bargaining agreement. For the reasons stated herein, we agree with the Respondent that deferral is appropriate.

Facts

The Union represents two units of the Respondent's employees: the technical unit and the service clerical unit. For the past 6 years, the Union has been the exclusive bargaining representative for the technical unit, and it has represented the service clerical unit for 3 years. In November 2000, the Union and the Respondent began negotiating the current contract. In approximately September 2001, the parties agreed to and signed a new contract (the Agreement). The Agreement is effective January 1, 2001, through December 31, 2003, for the technical unit and is effective January 1, 2001, through December 31, 2004, for the service clerical unit.

The Agreement provides employees with health benefits. The Respondent contributes a certain amount to cover the costs of insurance premiums, and the employees contribute the remainder. The employee contributions are made through deductions made from the employees' weekly pay. In addition, employees pay a copay at the time services are rendered. The Respondent has two insurance providers: Harvard/Pilgrim Health Care and Tufts Health Plan. It is undisputed that, during negotiations for the new Agreement, neither party proposed or discussed any changes or amendments to the existing health benefit plans.

Section 10.1 of the Agreement provides the following language under the caption titled *Health Insurance*:

> Workers who are authorized to regularly work twenty-four hours or more per week may participate in the Medical Center's health insurance plans on the same terms and conditions as offered to the other workers of the Medical Center applicable to said health insurance plans. The Medical Center agrees to bargain with the Union before implementing any changes to said plans and not to lower the Medical Center's contributions to the plans which are outlined in Appendix B.

Such language is identical to that contained in prior contracts. Appendix B is a chart indicating the amount of the employees' weekly paycheck deductions used for health care coverage.

After the parties signed the Agreement, the Respondent, on September 10, 2001,[3] distributed a memo to all its employees, the subject of which was "Medical and Dental Renewal Rates and Plan Changes." The memo highlighted the changes, effective October 1, that would be made to both health plans. Specifically, those changes are as follows: the copays under the Tufts plan for office visits increased from $3 to $8, from $25 to $50 for emergency room visits, and from $0 to $100 for inpatient treatment. Under the Harvard/Pilgrim Health Plan, copays for office visits increased from $10 to $15, and emergency room copays increased from $30 to $75. Further, under the Harvard/Pilgrim Plan, the memo notes a decrease in the number of days an employee can receive physical, speech, or occupational therapy, and an increase in the copays for durable medical equipment and prosthetic equipment.

In addition to the above changes, the memo announced an increase in the employees' weekly paycheck deduc-

[1] The Respondent has requested oral argument. The request is denied as the record, exceptions, and briefs adequately present the issues and the positions of the parties.

[2] As discussed infra, there were essentially three changes: (1) a change in copay, i.e., the money that employees must pay the health care provider; (2) a change in benefits covered by insurance; and (3) a change in premiums to be paid, respectively, by employees and the Respondent. Changes 1 and 2 were set forth in a memo of September 10, 2001. Change 3 was set forth in that memo and in appendix B, ostensibly a part of the collective-bargaining agreement.

[3] All subsequent dates are 2001 unless otherwise indicated.

tions. Specifically, in comparison with that contained in the most recent contract, the individual rate for the Harvard/Pilgrim Health Care increased approximately $2 per week, and the family rate increased $4 to $6 per week, depending on whether the employee was full or part-time. These changes in payroll deductions are consistent with appendix B as it appears in the current contract. However, that appendix B was not physically a part of the contract when it was signed on September 1, prior to the Respondent's issuance of the September 10 memo announcing the changes. Inexplicably, when the Union later assembled the contract for printing, it included the rates in the September 10 memo in appendix B. In the instant case, the Union relies on the prior appendix B, which was effective October 1, 2000.

The Union's representative, Mary Ellen Leveille, did not learn of or see a copy of the September 10 memo until approximately October 24, when a Union chairperson gave her a copy. On either October 25 or October 26, Leveille called the Employer's director of human resources, Sarah Jackson, and asked about the memo and the changes to the health plans. Leveille informed Jackson that Leveille knew nothing about these changes, to which statement Jackson responded "mea culpa." Jackson did not offer any reason for the alleged action and simply apologized to Leveille. Jackson then sent Leveille a copy of the memo.

Article 25 of the Agreement also contains a zipper clause, which reads:

> This Agreement incorporates the entire understanding of the parties on all issues which were or could have been the subject of negotiations and disposes of all issues between the parties. The Union acknowledges that during the negotiations which resulted in the Agreement, it has the unlimited right and opportunity to make demands and proposals with respect to all proper subjects of collective bargaining, that all subjects have been discussed and negotiated, and that the agreements contained in this Agreement were arrived at after free exercise of such rights and opportunities. The Union, therefore, voluntarily and without qualifications, waives any rights it may have had in this respect and agrees that the Medical Center shall not be obligated to bargain collectively with regard to any subject or matter referred to or covered by this Agreement or with regard to any subject or matter not covered or referred to in this Agreement, whether or not the subject or matter was within the knowledge or contemplation of the Union at the time it negotiated or signed this Agreement.

Finally, the Agreement's grievance and arbitration section set forth in Article 18 applies "[i]n the event of a controversy concerning the meaning or application of any provision of this Agreement."

Judge's Decision

The judge rejected the Employer's contention that the instant case should be deferred to arbitration. In doing so, the judge noted that the contract language regarding health benefits and what the employees were expected to pay under the contract for insurance benefits was clear and unambiguous. The judge specifically found that appendix B "clearly identifie[d]" the amount of employees' weekly deductions and that the "specific language" in appendix B addressed what the Agreement required the employees to pay under the health plan.[4] Given the clarity of the contract language, the judge determined that the expertise of an arbitrator was not required to interpret the language to establish whether the Respondent violated the Act. The judge then went on to decide that the Respondent violated Section 8(a)(5) by unilaterally changing the employees' health benefits without providing the Union notice and an opportunity to bargain over the changes.

Discussion

In *Collyer Insulated Wire*, 192 NLRB 837 (1971), the Board established the general rule that it would refrain from adjudicating an unfair labor practice issue that arises from the parties' collective-bargaining agreement if the agreement provides for arbitration as the method of resolving disputes over the meaning of its provisions. The *Collyer* decision identified the factors it would consider in determining whether a dispute is appropriate for deferral to arbitration. The Board held that it would defer when (1) the dispute arises within the confines of a long and productive collective-bargaining relationship; (2) no claim is made of employer animosity to the employees' exercise of protected rights; (3) the employer has asserted its willingness to arbitrate the dispute; (4) the parties' contract provides for arbitration in a very broad range of disputes; and (5) the dispute is well suited to resolution by arbitration. Id. at 841–842.

An application of the *Collyer* factors to the case at hand shows that deferral is appropriate. Here, the Respondent and the Union have enjoyed a bargaining relationship for at least 6 years. There is no claim of animosity on the part of the Respondent toward the employees' exercise of their protected rights. The Respondent has expressed its willingness to arbitrate the dispute, of-

[4] It is not clear whether the judge was referring to the revised appendix B or the prior one.

fering to waive any timeliness issue. Moreover, the arbitration clause, by its language, provides for arbitration in a broad range of disputes, including, no doubt, the instant dispute.[5] Most importantly, the instant dispute is well suited to resolution by arbitration because the meaning of the contract is at the heart of the dispute.

The issue in this case is whether the Agreement is free from ambiguity so as to make arbitration unnecessary. In our view, it is not.

With respect to the change in premiums, the Agreement provides, inter alia, that the Respondent will bargain before implementing any change to said plans. However, the Respondent plausibly argues that this provision refers to a change from one plan to another, not a change in an existing plan.

Our colleague says that provision refers both to changes from one plan to another and to changes in a plan. That *may* be correct, but that is classically a matter of contract interpretation, i.e., grist for an arbitrator's mill.

Our colleague also says that it is not reasonable to suppose that the Union would want to bargain about substituting one plan for another, and yet not seek to bargain about changes in an extant plan. We do not agree. The former change can involve changes in many matters, e.g., coverage, premiums, benefits, and promptness of payments. Thus, a union would be particularly concerned about such a change. We also disagree with our colleague's speculation that a union would "undoubtedly" be concerned about any change in an extant plan, and her assertion that the Union "clearly" did not intend to exclude changes in specific aspects of an existing plan from the prohibition against unilateral changes. We find that the concerns and intent of the Union, and how they might have been reflected in the agreement reached in bargaining, are not at all clear and, rather than engaging in conjecture, we leave these matters for an arbitrator to decide.

In support of its position, the Respondent points to bargaining history and past practice. More specifically, the Respondent points out that, under this language, the parties have bargained in the past only with respect to a change in carriers.

Our colleague seeks to refute the Respondent's argument by pointing to the 2000 bargaining over health insurance coverage. However, that bargaining involved the Respondent's change from a commercial health maintenance organization to a self-insured designated provider plan. Union representative Mary Leveille testified that, at the same time, the parties discussed changes in the monthly premiums listed in appendix B of the existing contract. There is no evidence that the parties even discussed the coverage, copays to providers, or other elements of preexisting plans. Thus, the parties' bargaining in 2000 is consistent with the interpretation of the contract language urged by the Respondent, i.e., that the parties have only bargained when there was a change from one plan to another. When there was such a basic change, the parties also "discussed" other related matters. The parties' discussion of premiums on the one occasion when they were negotiating a change from one plan to another does not necessarily demonstrate an intent to bargain over premiums, or a history of doing so, in the absence of such a basic change. Moreover, the record does not show that the parties bargained over coverage or copays of an existing plan in 2000 or at any other time.

Our colleague argues that the Union's acquiescence to prior changes is not a waiver. It may not be, but it at least sheds some light on the meaning of contract terms in existence at the time of the acquiescence.

The contract also says that the Respondent will not lower its contributions to the plans, "which are outlined in Appendix B." However, the instant case does not involve a lowering of employer contributions. It involves a raising of employee contributions. In addition, it may well be that the Union, by assembly of the document, agreed to the new version of appendix B. The terms of that appendix were set forth in the memo of September 10. Our colleague says that "inadvertent error is the only explanation" for the Union's assembly of the document. Although this is a plausible explanation, it is clearly not the only one. Phrased differently, there is a legitimate issue as to what was intended.

As noted above, there was also a change in copays and in covered benefits. However, contrary to our colleague's assertion, these matters are not set forth in appendix B or in the contract. The "zipper clause" arguably waives the Union's right to bargain with respect to matters not in the contract.

Our colleague relies on *St. Vincent Hospital*, 320 NLRB 42 (1995), for the proposition that the matters herein are "in the contract." However, that case actually supports our view. There, the Board considered whether the employer, by changing health plans, had unlawfully modified health insurance provisions that, unlike the provisions in this case, were explicitly included in the contract. The Board said that the issue of whether the existing plan was "contained in" the contract was "primarily a question of discerning the parties' mutual understanding" regarding the plan at the time of the change,

[5] The Agreement's grievance provisions require an employee to file a grievance in order for the dispute to proceed to arbitration. The lack of such a grievance in the case at hand is immaterial, however, as the filing of a grievance is not a prerequisite to deferral. *Urban N. Patman, Inc.*, 197 NLRB 1222 (1972).

which was essentially a matter of contract interpretation. Id. at 42. That is our point. In that case, moreover, neither party argued that the Board should defer to arbitration for the interpretation of the contract.

In sum, the agreement here is not free from ambiguity. Since the other factors favoring deferral are present here, we shall leave these matters to arbitral resolution.

ORDER

Pursuant to Section 10(c) of the National Labor Relations Act, the National Labor Relations Board orders that the complaint is dismissed, provided that: jurisdiction of this proceeding is retained for the limited purpose of entertaining an appropriate and timely motion for further consideration on a proper showing that either (a) the dispute has not, with reasonable promptness after the issuance of this Decision and Order, either been resolved by amicable settlement in the grievance procedure or submitted promptly to arbitration; or (b) the grievance and arbitration procedures have not been fair and regular or have reached a result that is repugnant to the Act.

Dated, Washington, D.C. September 8, 2003

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Robert J. Battista, Chairman

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Peter C. Schaumber, Member

(SEAL) NATIONAL LABOR RELATIONS BOARD

MEMBER LIEBMAN, dissenting.

The dispositive issue here is whether the collective-bargaining agreement the parties reached in September 2001, unambiguously required the Respondent to bargain with the Union before changing the terms of employees' health coverage. Unlike my colleagues, I believe that it did and that the Board accordingly should not defer this case to arbitration under the doctrine of *Collyer Insulated Wire*, 192 NLRB 837 (1971).[1]

I.

The terms of the 2001 Agreement were established in a three-page memorandum of understanding (MOU), which the parties signed on August 15, 2001. That MOU, by its terms and format, amended or deleted certain enumerated provisions of the prior contract and extended all the others—including all of its provisions on health insurance coverage—unchanged.[2] The health coverage provisions included Section 10.1, which recited that:

> The Medical Center agrees to bargain with the Union before implementing *any changes to* said [health benefit] plan(s). [Emphasis added.]

Those provisions also included the prior contract's "Appendix B," which specified the amounts for weekly employee contributions for health insurance premiums.

During negotiations for the 2001 contract, there was no proposal or even discussion of *any* changes to existing health coverage.

The new contract, established by the MOU, was duly ratified and signed by both parties on September 1, 2001, and the record shows that there was no subsequent negotiation or ratification of any later modification of its terms.[3]

With respect to health coverage, the Respondent remained bound by all the preexisting contract terms, including the requirement that it bargain before making "any changes to said plans," and the preexisting employee premium contribution amounts.[4] Yet the Respondent, less than a month after agreeing to these terms, unilaterally imposed increases in employee premium contributions, increases in required copays for visits to health care providers, and additional changes in covered benefits. When the Union's representative challenged this action as impermissible, the responsible management official admittedly replied "Mea culpa." The Respondent's witness also admitted at the hearing that it had given the Union notice and bargained over such changes in the past.

II.

It is hard to imagine how the 2001 agreement could be any plainer. No purpose, then, is served by deferring to arbitration.

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[1] See *Grane Health Care*, 337 NLRB No. 58, slip op. at 5 (2002); *R.T. Jones Lumber*, 313 NLRB 726, 727 (1994); *American Commercial Lines*, 296 NLRB 622, 623 fn. 8 (1989); *Teamsters Local 284*, 296 NLRB 19, 22–23 (1989); *Struthers Wells Corp.*, 245 NLRB 1170, 1171 fn. 4 (1979), enfd. mem. 636 F.2d 1210 (3d Cir. 1980), cert. denied 452 U.S. 916 (1981).

[2] As my colleagues appear to agree, the judge was clearly mistaken in stating that the MOU changed employee premium contributions.

[3] There is no evidence or contention that the Respondent and the Union discussed changes with respect to health coverage after the new contract was ratified and signed on September 1, 2001. My colleagues point out that the union representative later attached an "Appendix B" containing different employee premium contributions to the draft she sent to the printer in November. But given the importance of the subject, there is no reasonable basis for my colleagues' speculation that the Union, merely "by assembly of the document," agreed to any of the Respondent's unilateral changes. Inadvertent error is the only logical explanation for the inclusion of "Appendix B."

[4] For this reason, my colleagues are incorrect in stating that copays and covered benefits "were not set forth in Appendix B or in the contract."

The Respondent contends that Section 10.1's ban on "any" unilateral "changes to the plans" applies only to changes entirely from one "plan" to another. The majority finds this interpretation "plausible." It is refuted, however, by the plain language of the agreement, as well as the parties' bargaining history. As a matter of common usage, "any changes *to*" a thing necessarily includes changes in the thing's elements, here changes to the terms of the plans—and not just a change *of* plans. Had the parties intended to cover only changes from one plan to another, they surely would have used different language. It also violates common sense to conclude that the Union would have intended to require bargaining only when the Respondent replaced one health plan with another—a step that might not have affected employees' coverage or pocketbooks—and not when the Respondent changed the actual terms of coverage and the cost to employees.[5] My colleagues point out that a change from one health plan to another can involve alterations in coverage, premiums, and benefits, and that a union would therefore be "particularly concerned" about such a change. That is not in dispute. Rather, the point is that a union would undoubtedly be concerned about any one of those specific alterations and that the Union here clearly did not intend to exclude them from the prohibition on unilateral changes.

The Respondent's crabbed reading of Section 10.1 is based on its assertion that prior to 2001, with respect to health coverage, the parties bargained only over changes from one plan to another. This assertion, in turn, relies on selected excerpts from the record of the parties' bargaining history from 4 years earlier. However, even assuming that such extrinsic evidence could be considered,[6] the Respondent conveniently ignores the parties' more recent negotiations in 2000. At that time, as the Union and Respondent witnesses agreed, the Respondent gave notice of and bargained over all of its proposed changes in health coverage, not just over changes to new health plans. My colleagues accept the Respondent's conclusory assertion that the negotiations in 2000 involved only a change from a commercial health plan to a self-insured plan, but the record shows otherwise.[7] In any case, it is well established that a union's acquiescence to a particular change in a term of employment does not waive its right to bargain over similar changes in the future.[8]

Finally, because the Respondent's actions involved terms of employment established by the agreement and violated a specific contractual prohibition against unilateral changes of those terms, I reject the majority's suggestion that the "zipper clause" in the agreement "arguably waives the Union's right to bargain with respect to matters not in the contract" and somehow might authorize the Respondent's actions. The matters at issue here *were* "in the contract" and thus could not be unilaterally changed. See *St. Vincent Hospital*, 320 NLRB 42, 42 (1995).

I predict an arbitrator will make short work of the Respondent's arguments. But that is exactly why we need not defer to arbitration and should instead find that the Respondent violated Section 8(a)(5) of the Act.

Dated, Washington, D.C. September 8, 2003

Wilma B. Liebman, Member

NATIONAL LABOR RELATIONS BOARD

[5] In addition to prohibiting "any change to" the health plans, Sec. 10.1 barred the Respondent from reducing "the Medical Center's contributions to the plan(s), which are outlined in Appendix B." My colleagues point out that the bar pertaining specifically to contributions does not refer to employee contributions. In fact, however, appendix B in both the prior and the 2001 contracts "outlined" only employee contributions, not the Respondent's. Accordingly, the explicit bar against changes in contributions cannot be read to authorize unilateral changes in employee contributions.

[6] As the judge correctly noted, in view of the unambiguous terms of the contract, such extrinsic evidence was irrelevant.

[7] Mary Leveille, the Union's representative, testified that in the fall of 2000, the Respondent notified the Union that it was considering changes in employee premium contribution rates "and they asked us to bargain with them over those changes, so we met with the hospital's counsel and their vice president of human resources . . . to discuss the changes in the plan *and the monthly premiums*, and this [appendix B in the 2000 contract] is the document that we came out with." Similarly, Sarah Jackson, the Respondent's director of human resources, testified that the vice president of human resources had "discussions with the Union concerning changes in the health care premiums *and* changes in the plan." My colleagues' purported distinction between the parties' "discussion of premiums" and "an intent to bargain over premiums," and their attempt to characterize employees' weekly insurance premium contributions as correlated only to bargaining over a change from one entire plan to another, has no factual basis. The point, in any case, is that the parties' past bargaining history does not, as the Respondent contends, support its contention that the contract's requirement of bargaining over "any changes to said plans" is limited solely to changes from one plan to another.

[8] E.g., *Georgia Power*, 325 NLRB 420, 421 fn. 9 (1998); *Midwest Power Systems*, 323 NLRB 404, 407 (1997), enfd. mem. denied on other grounds 159 F.3d 636 (D.C. Cir. 1998); *Bath Iron Works*, 302 NLRB 898, 900–901 (1991).

Avrom J. Herbster, Esq., for the General Counsel.
Geoffrey P. Wermuth, Esq. (Murphy, Hesse, Toomey & Lehane), of Boston, Massachusetts, for the Respondent.
Mary Ellen Leveille, Representative, of Hyannis, Massachusetts, for the Charging Party.

DECISION

STATEMENT OF THE CASE

EARL E. SHAMWELL JR., Administrative Law Judge. This matter was heard by me in Boston, Massachusetts, on June 17, 2002, upon a complaint dated February 28, 2002, charging Caritas Good Samaritan Medical Center (the Respondent), with violations of Section 8(a)(1) and (5) of the National Labor Relations Act (the Act). This complaint was based on charges filed by the SEIU, Local 767, Hospital Workers Union, AFL–CIO (the Union), on November 11, 2001, and as amended on February 28, 2002, with the National Labor Relations Board (the Board) in Region 1. The complaint charges that the Respondent violated Section 8(a)(1) and (5) of the Act by changing benefits, including copays, offered under the health insurance plans provided for in the collective-bargaining agreements in effect between the Respondent and the Union.

On March 7, 2002, the Respondent timely filed its answer admitting, among other things, the jurisdictional allegations, the labor organization status of the Union, the agent or supervisory status of Sarah Jackson, director of human resources, and Joan C. Carroll, benefits and compensation manager. The Respondent generally denied committing any unfair labor practices and asserted certain defenses.

Based on my review and consideration of the entire record of this case and my observation of the witnesses and their demeanor, as well as the arguments and briefs of the General Counsel and Respondent,[1] I make the following

FINDINGS OF FACT

I. JURISDICTION

The Respondent is engaged in the operation of a hospital providing inpatient and outpatient medical care in Brockton, Massachusetts. Annually, the Respondent, in conducting its business operations of providing medical care, derived gross revenues in excess of $250,000 from the Brockton, Massachusetts hospital, and purchased and received at this hospital goods valued in excess of $5000 directly from points outside the Commonwealth of Massachusetts. The Respondent admits, and I find and conclude, that at all times material, it is, and has been, an employer engaged in operations affecting commerce within the meaning of Section 2(2), (6), and (7) of the Act, and has been a health care institution within the meaning of Section 2(14) of the Act.

II. LABOR ORGANIZATION

The Union is a labor organization within the meaning of Section 2(5) of the Act.

[1] The Charging Party did not submit a separate brief.

III. ALLEGED UNFAIR LABOR ALLEGATIONS

A. Background

The Respondent operates a hospital that provides inpatient and outpatient care for the Brockton, Massachusetts region. The Union represents two portions of the Respondent's employees, the technical unit and the service clerical unit. The Union has been the exclusive collective-bargaining representative of the technical unit for 6 years and the exclusive collective-bargaining representative of the service clerical unit for 3 years. The collective-bargaining agreements (CBAs), the Union has bargained for the units are identical in content, except for the commencement and expiration dates of the agreements.[2] The Respondent and the Union began negotiating on the current contract in November 2000, and settled in approximately September 2001. The current contract provides the unit employees, among other things, with health insurance benefits, with the Respondent agreeing to contribute a certain amount to cover the costs of the insurance premiums, and the employee agreeing to cover a portion of the costs through a "co-pay."[3] During the most recently concluded contract negotiations, there was no proposal put forth, or discussion of modifying, or amending the existing health insurance benefit plan.

B. Preliminary Discussion of the Legal Principles Applicable to the 8(a)(5) and (1) Allegations

An employer's unilateral change to a matter that is a subject of mandatory bargaining under Section 8(d) of the Act is a violation of the duty to bargain collectively, as required by Section 8(a)(5) of the Act. *NLRB v. Katz*, 369 U.S. 736 (1962). Insurance benefits for employees are considered among those matters that are subjects of mandatory bargaining, and an employer's unilateral modification of such benefits constitutes an unfair labor practice. *Allied Chemical & Alkali Workers of America, Local 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157 (1971). Any material, substantial, or significant changes made by an employer to an employee's health insurance benefits is considered a violation of Section 8(a)(5) and (1) if that employer has not first provided the employees' bargaining representative notice and an opportunity to bargain. *Pioneer Press*, 297 NLRB 972, 976 (1990). If it is argued that the Union has waived the right to bargain over mandatory subjects of bargaining, the waiver must be clear and unmistakable. *Metropolitan Edison Co. v. NLRB*, 460 U.S. 693, 708 (1983).

The Board may defer issues involving an interpretation of contract language to arbitration when the meaning of the language is unclear and would best be determined by an arbitrator with expertise in the field. *Collyer Insulated Wire*, 192 NLRB 837, 842 (1971). However, when the language at issue is clear

[2] Under article 27 of the "Union Contract," the duration of the CBA for the technical unit runs from January 1, 2001, to December 31, 2003, while the duration of service/clerical unit's CBA runs from January 1, 2002, to December 31, 2004. (GC Exh. 2.)

[3] The amount of the deductions made from the employees' weekly pay is listed in the contract in "Appendix B." This appendix lists the rates for the two insurance plans the employer offers, as well as the rates for part-time and full-time employees, and the rates for individual and family coverage.

and unambiguous, the interpretative skills of an arbitrator are unnecessary, and the Board is thereby not required to defer the issue to arbitration. *Grane Health Care, Inc.*, 337 NLRB No. 58, slip op. at 5 (2002). Further, when an employer repudiates a collective-bargaining agreement by modifying terms which involve a subject of mandatory bargaining, it is within the Board's authority to deem such modification a violation of Section 8(a)(5) and (1). *Oak Cliff-Golman Baking Co.*, 207 NLRB 1063, enfd. 405 F.2d 1302 (5th Cir. 1974), cert. denied 423 U.S. 826 (1975).

C. The Respondent's Alleged Unilateral Changes to Health Insurance Benefits

Mary Ellen Leveille testified at the hearing; she is a representative for the Union and has been employed by the Union since 1997. As a union representative, Leveille stated that she currently is the lead negotiator for the technical unit and the service clerical unit at the Respondent's hospital (the Medical Center), and was the lead negotiator of the current contract between the Union and the Medical Center. Leveille assisted in the negotiations of the two prior contracts of the Union with the Medical Center, but did not have a representational role.

According to Leveille, the last bargaining session between the parties occurred in August 2001. On about August 15, 2001, Leveille and Sarah Jackson, for the Respondent, signed a memorandum of agreement for the contract, signifying the amendments to be made to the appropriate sections in the prior contract. Regarding the health plan, this memorandum of agreement indicated that the employee would pay 36 percent of the cost of the health insurance coverage and the Respondent would cover the remaining 64 percent. In comparison to the prior contract, this translated into roughly a $2 increase, weekly, in the individual rate for the Harvard Pilgrim Health Care plan, and a $4 to $6 increase in the family rate, depending on whether the employee is part time or full time. With the amendments agreed upon and ratified by the union membership, Leveille made the appropriate changes to the existing contract and sent it to the Respondent for review. The Respondent then signed off on the amendments, thereby settling the contract on September 1, 2001.

In late October, Leveille approximated the date at October 24, 2001, Leveille was presented with a memo from the Respondent regarding changes in health insurance. According to Leveille, Mary Ellen Quigley, a union chairperson, brought the memo to Leveille's attention at a steward's training session. Quigley provided Leveille with a copy of the document given to the employees and asked Leveille if she knew anything about the memo. Leveille told Quigley that she did not, but that she would look into the matter immediately.

Dated September 10, 2001, the memo,[4] in essence, "highlights" the changes to be made on October 1, 2001, to the health plans the Respondent offers employees. The change the memo indicates is an increase beyond the negotiated changes in employee copayments for both the Tufts Health Insurance and Harvard Pilgrim Health Plan. Specifically, copayments under the Tufts plan for office visits increased from $3 to $8, from $25 to $50 for emergency room visits, and from $0 to $100 for inpatient treatment. For those covered under the Harvard Pilgrim plan, copays for office visits increased from $10 to $15, and emergency room copays increased from $30 to $75. Further, for those covered by the Harvard Pilgrim plan, the memo notes a decrease in the amount of days an employee can receive physical, speech, or occupational therapy and an increase in the price of durable medical equipment and prosthetic equipment.

Leveille testified that she called the Respondent's director of human resources, Sarah Jackson, on October 25 or October 26, 2001, regarding the memo and its changes to the employees' health insurance plan. According to Leveille, she asked Jackson, "What's going on? I knew nothing about this change." To which Jackson responded, "Mea culpa." Leveille stated that she then stated to Jackson that the Respondent already had a National Labor Relations Board posting up in the Medical Center for not bargaining in good faith with the Union and that she (Leveille) could not believe that the Respondent would make changes to something for the bargaining unit without notifying us [the Union] or bargaining over it.[5] As Leveille recalled the conversation, Jackson did not offer any reason for the alleged actions and simply apologized to Leveille. Leveille then asked Jackson to send a copy of the memo to the Local directly from the Respondent's human resources department, which Jackson did. Leveille stated that once she had received the memo from the human resources department, she proceeded to file the present unfair labor practice charges with the National Labor Relations Board.[6]

In addition to her recollection of the above events, Leveille testified that at no time between bargaining and her conversation with Jackson did she receive notice of the changes in the health care plan, nor did anyone else from the Union's office receive such notification. She also noted that it was the usual practice of the Respondent and the Union to email or call one another in order to give notice of a possible change and the need to bargain. Leveille stated that the Respondent did not follow this practice and did not notify the Union of a possible change in the terms of the health insurance plan for purposes of bargaining. Leveille did concede that some members of the unit had seen the memo before Leveille had been presented with it, and that she had never told the Respondent that notice must go directly to her and not the union stewards or chairpersons.

Discussion and Analysis

The General Counsel alleges that the Respondent unilaterally changed the health insurance benefits of bargaining unit employees without bargaining with the Union by increasing employee copays, in violation of Section 8(a)(5). In response to these allegations, the Respondent asserts that the General Counsel has failed to show that the Respondent has made a unilateral change under Section 8(a)(5), or otherwise unlaw-

[4] See GC Exh. 7, a copy of the memorandum which was addressed to all benefit-eligible employees of the Respondent.

[5] See GC Exh. 8, settlement agreement between the hospital and the Union.

[6] In testimony for the Respondent, Sarah Jackson, the Respondent's director of human resources, corroborated Leveille's recitation of the facts leading up to the filing of the unfair labor practice charges.

fully modified the contract, and that the Union has waived its right to bargain over changes in the health insurance rates. Further, the Respondent argues that the issue brought before the Board in the present case should be deferred to the current CBA's grievance and arbitration procedure.[7]

The Respondent does not challenge Leveille's version of the facts surrounding the charges, but contends that the case should be deferred to arbitration because the CBA supports its interpretation that the Respondent is only required to notify the Union if and when it elects to change from one health insurance plan to another, and not merely upon a shift in insurance copay rates. The language the Respondent relies upon, section 10.1 of the CBA with the Union, states: "The Medical Center agrees to bargain with the Union before implementing any changes to said plan(s) and not to lower the Medical Center's contribution(s) to the plan(s) which are outlined in Appendix B."

In support of its deferral argument, the Respondent cites *Burns Security Services v. NLRB*, 146 F.3d 873 (D.C. Cir. 1998). In Burns, the court stated that when an employer plausibly claims that there is a contractual justification for changes the employer makes in the terms and conditions of employment, the Board should defer the case to arbitration so as to allow the parties to exhaust their contractual remedies. Id. at 877. In my view, however, *Burns* is distinguishable from the present case.

In *Burns*, the employer decided to forgo holiday pay for employees receiving workers' compensation after learning that State law allowed it to do so. After the change was made, the union filed 8(a)(5) charges, alleging that the elimination of holiday pay for those receiving workers' compensation was a unilateral change. The contract language in question stated, "In order to receive [holiday pay], the employee must fully complete his last regularly scheduled work day before the holiday itself and first regularly scheduled work day after the aforesaid holidays [sic]." Id. at 874. The issue of whether employees on workers' compensation would receive holiday pay was not expressly addressed in the CBA, and both parties argued that the language supported their position.

In the instant case, the General Counsel does not argue that the terms regarding health insurance rates are implied or "extra-contractual." The General Counsel asserts that the contract language concerning health insurance benefits is not only expressed but is clear and unambiguous. I agree with the General Counsel. Notably, section 10.1 clearly states that the Respondent will bargain with the Union before making any changes in the plan(s) and, further, that the Respondent will not lower their rate of contribution as outlined in "Appendix B." Appendix B clearly identifies the rate of deductions taken from the weekly salaries of employees receiving health insurance benefits, according to the plan under which the employee is covered. In my view, there is no question that this very specific language in appendix B addresses the issue of what the employees are expected to pay for insurance benefits under the terms and conditions of the CBA. In such instances where the contract language is clear and unambiguous, the Board is not required to defer the matter to arbitration and may interpret the language in order to determine if the Respondent has violated the Act. *Struthers Wells Corp.*, 245 NLRB 1170, 1171 (1979), enfd. 636 F.2d 1210 (3d Cir. 1980), cert. denied 452 U.S. 916 (1981).

Further, resolving the issue of whether or not this language allows the Respondent to unilaterally change the rate of copay for employees does not, in my view, require the expertise of an arbitrator conversant in practices of the industry. Appendix B clearly delineates the copay rates for employees, making the interpretative skills of an arbitrator unnecessary. *Grane Health Care, Inc.*, supra.

It is my view that the expressed contract language in question is clear and unambiguous. Accordingly, I find that deferral is not appropriate or warranted, and that the matter here falls squarely and properly within the Board's jurisdiction, as it is the Board's duty to promote industrial peace by encouraging, and thereby enforcing, the collective-bargaining process. See *Collyer Insulated Wire*, supra.

The Respondent also contends that the Union has waived its right to bargain over a change in the rate of employee copays. The Respondent acknowledges that such a waiver must be clear and unmistakable and argues that an express waiver by the Union may be gleaned from the bargaining history between the parties and the parties' past practices. In support, the Respondent introduced notes from past bargaining sessions.[8] However, the Board has held when the parties have agreed upon contract provisions that are clear and unambiguous, extrinsic evidence is irrelevant and will not be considered. *America Piles, Inc.*, 333 NLRB 1118, 1119 (2001); *NLRB v. Electical Workers Local 11*, 772 F.2d 571, 575 (9th Cir. 1985). Accordingly, I would reject this argument, and would find and conclude that the Union did not waive its right to bargain over changes in the amounts of employee copays.[9]

Based on the foregoing, I would find and conclude that the Respondent violated Section 8(a)(5) of the Act by unilaterally changing a mandatory subject of bargaining without providing the Union an opportunity to bargain over the issue. *U.S. v. Katz*, supra; *Allied Chemical & Alkali Workers of America, Local Union No. 1 v. Pittsburgh Plate Glass Co.*, supra.

CONCLUSIONS OF LAW

1. Good Samaritan Medical Center, the Respondent herein, is an employer engaged in commerce within the meaning of the Act.

2. The Union is a labor organization within the meaning of Section 2(5) of the Act.

[7] This grievance and arbitration procedure is enumerated under art. 18 of the current CBA.

[8] At the hearing, the Respondent introduced the notes from previous bargaining sessions during the testimony of Michael Bertoncini, an attorney who assisted the Respondent in negotiations with the Union in 1997. Bertoncini had kept the bargaining notes the Respondent submitted as evidence and testified at hearing on the content of his notes and exchanges that took place between the Respondent and the Union during the 1997 negotiations. Bertoncini's testimony on these previous bargaining sessions, as well as the Respondent's other exhibits relating to previous negotiations, is, in my view, extrinsic evidence.

[9] I further note that the General Counsel correctly asserts that the CBA itself excludes the use of parol evidence, as article 25 states that, "no prior agreements or understandings, oral or written, shall be controlling or in any way affect the relations between the parties . . . ."

3. By unilaterally making changes to health insurance benefits, a mandatory subject of bargaining, the Respondent violated Section 8(a)(5) and (1) of the Act.

4. By the aforesaid conduct, the Respondent has engaged in unfair labor practices affecting commerce within the meaning of the Section 2(6) and (7) of the Act.

5. For purposes of the present order, the Respondent has not violated the Act in any other way, manner, or respect.

Having found that the Respondent has engaged in certain unfair labor practices in violation of Section 8(a)(1) and (5) of the Act, I find that it must be ordered to cease and desist and to take certain affirmative action designed to effectuate the policies of the Act. In effectuating the Act's objectives to facilitate the productive resolution of industrial disputes and to safeguard the nation's commerce from injury, I find the following actions appropriate.

In light of the Respondent's unilateral changes to the health insurance benefits bargained for by the employees, I order that the Respondent immediately rescind these unilateral changes to health insurance benefits and provide those benefits bargained for by the employees. The Respondent shall make unit employees whole for the loss they have suffered as a result of the unilateral increase in the cost of copayments and the unilateral decrease in therapy and rehabilitation coverage by reimbursing. The Respondent shall make unit employees whole by paying all health insurance contributions required under the current contract the Respondent has with unit employees, which took effect October 1, 2001, to the extent that such payments have not been made, or that employees have not been made whole for their ensuing medical expenses. This shall include reimbursing, with interest, all employees who have had to pay medical expenses exceeding those copayments agreed upon by the Respondent in the current contract, as a result of the Respondent's unlawful unilateral change. The Respondent shall continue to make such contributions to the respective health insurance plans until the parties negotiate a new contract in good faith, or they reach an impasse. *Imperial House Condominium, Inc.*, 279 NLRB 1225, 1228 (1986).

On these findings of fact and conclusions of law and on the entire record, I issue the following recommended[10]

ORDER

The Respondent, Caritas Good Samaritan Medical Center, Brockton, Massachusetts, its officers, agents, successors, and assigns, shall

1. Cease and desist from

(a) Refusing to bargain collectively with the SEIU, Local 767, Hospital Workers Union, as the exclusive representative of employees in the following bargaining units:

> The Technical Unit. All employees covered by Article 1, Section 1.1., subsection A, of the collective-bargaining agreement between the Respondent and the Union effective January 1, 2001 to December 31, 2003.
>
> The Service/Clerical Unit. All employees covered by Article 1, Section 1.1., subsection B, of the collective-bargaining agreement between the Respondent and the Union effective January 1, 2002 to December 31, 2004.

(b) Implementing unilateral changes in the health insurance benefits of the unit employees.

(c) In any like or related manner interfering with, restraining, or coercing employees in the exercise of the rights guaranteed them by Section 7 of the Act.

2. Take the following affirmative action necessary to effectuate the policies of the Act.

(a) Revoke the unilateral changes implemented in October of 2001 in the health insurance benefits provided to unit employees.

(b) Make whole the employees for any losses suffered by them as the result of the unilateral change in their health insurance benefits.

(c) Bargain in good faith by notifying the Union and providing to the Union an opportunity to bargain over any proposed changes in health insurance benefits, or any other terms and conditions of employment.

(d) Preserve and, within 14 days after service by the Region, post at its facility in Brockton, Massachusetts, copies of the attached notice marked "Appendix."[11] Copies of the notice, on forms provided by the Regional Director for Region 1, after being signed by the Respondent's authorized representative, shall be posted by the Respondent immediately upon receipt and maintained for 60 consecutive days in conspicuous places including all places where notices to employees are customarily posted. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. In the event that during the pendency of these proceedings, the Respondent shall duplicate and mail, at its own expense, a copy of the notice to all current employees and former employees employed by the Respondent at any time since October 1, 2001.

(e) Within 21 days after service by the Region, file with the Regional Director a sworn certification of a responsible official on a form provided by the Region attesting to the steps that the Respondent has taken to comply.

(f) IT IS FURTHER ORDERED that the complaint is dismissed insofar as it alleges violations of the Act not specifically found.

Dated, Washington, D.C. September 12, 2002

APPENDIX

NOTICE TO EMPLOYEES
POSTED BY ORDER OF THE
NATIONAL LABOR RELATIONS BOARD
An Agency of the United States Government

[10] If no exceptions are filed as provided by Sec. 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec. 102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.

[11] If this Order is enforced by a judgment of a United States court of appeals, the words in the notice reading "Posted by Order of the National Labor Relations Board" shall read "Posted Pursuant to a Judgment of the United States Court of Appeals Enforcing an Order of the National Labor Relations Board."

The National Labor Relations Board has found that we violated the Federal labor law and has ordered us to post and obey this notice.

FEDERAL LAW GIVES YOU THE RIGHT TO

Form, join, or assist a union
Choose representatives to bargain with us on your behalf
Act together with other employees for your benefit and protection
Choose not to engage in any of these protected activities.

WE WILL NOT make unilateral changes to the health insurance benefits of unit employees.

WE WILL NOT refuse to bargain in good faith with the Union as the exclusive representative of the unit employees.

WE WILL NOT in any like or related manner interfere with, restrain, or coerce employees in the exercise of rights guaranteed to employees by Section 7 of the Act.

WE WILL rescind our September 10, 2001 notice of medical and dental renewal rates and plan changes, and make the unit employees whole for any and all losses which they may have suffered as a result of the unilateral change in health insurance benefits, with interest.

WE WILL restore our worker weekly premium deductions, co-pays, and plan requirements for our health care plans to the level they were at prior to October 1, 2001.

WE WILL bargain in good faith with the Union concerning any changes in our medical and dental insurance health care plans for the unit employees.

CARITAS GOOD SAMARITAN MEDICAL CENTER